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ABSTRACT

This report presents the thesis that most college health services will have to undergo critical reexamination and drastic changes before students can rightfully participate as consumers and before effective planning becomes standard operating procedure. The two basic areas where these changes will have to occur are: (1) in consideration and treatment of the student as a dues paying consumer, along with all the other members of society; and (2) in far bolder plans for consumer participation, comprehensiveness, and planning mechanisms than are now the case in most college communities. In addition, the concept of consumer participation is explored to reveal that there are gaps between practice and promise not only on college campuses but in the whole health care system. In addition, the nature of health planning and evaluation is explored to reveal that the most effective planning process is not always harmonious, that negotiation is the language, and that planning and evaluation necessarily presume medical, social, and political dimensions. (Author/TA)

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THE ROLE OF CONSUMERS IN PLANNING AND EVALUATION OF COLLEGE HEALTH PROGRAMS

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by

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1.0 INTRODUCTION

If you have had a chance to see a copy of this paper you will note that the title differs slightly from the original charge to "The Role of Consumers in Planning and Evaluation of College Health Programs."

The first change, replacing student with consumer, may not now appear significant but it is fundamental to my remarks today.

The second difference was deletion of the word "changing"; for explanation, let me get right into the basic thesis of this paper which is as follows:

Most college health services will have to undergo critical reexamination and drastic changes before students can rightfully participate as consumers, and before effective planning becomes standard operating procedure.

There are two basic areas where these changes will have to occur. First, the idea that students comprise a separate class of consumers has to be revamped, because the current parochial concepts of "student medicine" and "in-loco parentis" have little function in a modern typology of comprehensive health services. Past rationales have included the arguments that students present distinct illness combinations, or that students have special personal and educational requirements. With this there is no quarrel, but is it not true that such arguments apply equally well to all other age and population groups? While these consumer needs exist they are really not significant enough to justify segregating the student health service and treating students as second class consumers. One author arguing for comprehensive national health insurance wrote, "Segregation of individuals on the basis of race,

income, and social class, and practices offensive to human dignity are no longer acceptable in the health field."(3) If the A.C.H.A. and its members are in accord with the principles of comprehensive health services, which I believe they are, then they will understand that any health service that is effective and humanitarian should be able to deal with any special medical or personal requirements of its patients, regardless of their educational or social status. But fostering a separate and artificial branch of medicine serves only to reinforce the stereotypes that consumers and professionals have of each other. Causes for this development lie in both historical precedent and the administrative relationships between the health service and the parent institution.

A later section will deal with this matter at length, but for now let me throw out the idea that the student has to be considered and treated as a dues-paying consumer, along with all the other members of society.

The second area where change is needed is closely related to the preceding discussion, and that is the manner in which any health care institution is held accountable to its consumers and the rest of its community. This will require far bolder plans for consumer participation, comprehensiveness, and planning mechanisms than are now the case in most college communities.

The implication of these changes is that college health services might join in a comprehensive scheme for the delivery of health care on a rational, community-wide basis without regard to an individual's status within the university or college. If the dictates of efficiency, quality, and access indicate that the college health service

should partially or completely join in a community health plan, then, so be it, in order that care is delivered regardless of race, religion, or student I.D. number.

The remainder of this paper is devoted to supporting the thesis, and presenting some suggestions for change.

First the concept of consumer participation will be explored to reveal that there are gaps between promise and practice not only on college campuses but in the whole health care system. While there are unique barriers to participation in college health services, they are only symptomatic of a general unresponsiveness throughout the country.

Second, the nature of health planning and evaluation will be touched on to reveal that the most effective planning process is not always harmonious, that negotiation is the language, and that planning and evaluation must necessarily presume medical, social, and political dimensions.

The third and final section will present a context in which participation is considered the means by which consumers enter into a bargain or a social contract for their health care.

2.0 CONSUMER PARTICIPATION

Consumer Participation - Is It So Important?

We are all well aware that many professional health conferences in recent years have been heavily consumed by the consumer, either in person or by proxy, and that the American College Health Association is no exception as I am sure you will all agree after Boston last year. In fact, the topic of consumer participation goes back much further in A.C.H.A.'s history than just last year. In 1954, at the fourth National Conference on Health in Colleges, one committee reported, "In the planning, operating, and evaluating of college health programs in all aspects there are manifest advantages, both immediately practical and broadly educational, to be gained from student participation."(20) Last year's conference was even more productive in its various recommendations, most of which at least nominally endorsed consumer participation; some suggested advisory roles; some even went so far as to include students in determining budgets and hiring personnel; and there was one recommendation that student consumers be able to request an outside evaluation of their health service.(21) That we are here today devoting this General Session to this topic is just further evidence that you are concerned, and, I hope, that some constructive changes will evolve; but those changes will not occur until there is fundamental agreement about the concept of consumer participation, which is rooted in historic precedent and which is now being tailored by social change. One author, more eloquent then I wrote that, "health is a basic element for the attainment of quality of life objectives. To be understood, (it)... must be seen as a part of a larger movement in which humanitarian

values are acquiring more and more importance in post-industrial society."[3] So while the consumer's faith in the system is waning, and expectations are waxing, even more fundamental questions arise as to just what is the nature of this odd social contract called the health care system.

You may be questioning my use of the term social contract, but in a very real sense that is what health care is all about; it didn't just happen. People have always wanted health care, and their various communities provided the needed resources. Because there has always been strong community identity with health care some people believe that ownership of health services, for example, is an obsolete notion; this partly accounts for the longstanding, ethical constraints against for-profit health care. In an historical review of this topic, Notkin and Notkin noted that, "Community participation and, indeed, community control, of health services in this country is very old indeed...in a number of instances it antedates the American Revolution."[15] And even today, they go on, "with the exception of the Kaiser Foundation, practically all prepaid, comprehensive, group practices are either totally community controlled or have a major consumer voice in all decisions except technical medical ones."[15] If you look even further to examine the role of the consumer at Neighborhood Health Centers or at some community hospitals the evidence begins to pile up, that changes are occurring. Even the concept that health care is a service is giving way to the notion that it is a public utility or a commonweal function that should serve the community at large and not just those who walk in the door of a health facility.[11]

But historic precedent ought not be the pervading reason why student consumers should participate in planning and evaluation of their health services; there are some more practical reasons.

The authors of a very recent article, for example, contended that participation is mandatory to overcome deficiencies and to ultimately improve the management of resources, for otherwise health care institutions become self-serving.(9a) So not only can consumers aid in improving the delivery of health care, but their participation is likely to increase their acceptance and utilization. Writing on these salutary effects at a Neighborhood Health Center, one author cites, "educational theory that people who participate in identifying a problem and thinking through a proposed solution would be more committed to carry out that solution, less resistant to change, and have increased opportunities for learning."(7) At last year's conference a student, very active at his own college health service, presented a paper in which he suggested that health education and participation go hand in hand as factors in utilization.(16) The success, even, of special programs like screening are highly dependent on the public's acceptance of the program, which is, in turn, often dependent on degrees of participation.(18)

Another important reason or issue behind this movement is that of community psychology. In an era of large and impersonal organizations, the health service is not immune from the criticisms of the consumer, which may sound loudest among students or other disenfranchised groups. In their review article, the Notkins wrote, "Quite understandably people who have voices for the first time in their lives tend to speak loudly. Also understandably, this has been quite threatening

to the existing community power structure."[15] And, indeed, many of you have probably been quite troubled if you have been faced with consumer demands at your schools. But the facts that consumers do "want in,"[9a] do want to participate, and do want to assume responsibility, are perhaps the healthiest and most compelling reasons.

So What's Bugging the Consumer?

The shortcomings of the health care system, as you know, are many, and they are certainly not going to all be solved by consumer participation. Nevertheless there are a number of failings that the consumer is more likely to be aware of then the providers, especially in the manner patients are handled as they make their way through the system. The manner in which providers and consumers react to each other is largely a function of role definitions which are, in turn, largely conditioned by the contractual encounter. The old family doctor in his horse and buggy who sounds like a Peppridge Farm commercial or a Marcus Welby is certainly going to act far differently toward his patients than, say, an Army doctor on sick call whose job conditions him to think all his patients are trying to get out of work. The interaction between doctor and patient can't help but be affected by the contractual environment; and this is just another reason why consumers feel that their participation in important decision making will increasingly sensitize providers to their particular needs.

A very interesting book was published last year called the American Health Empire[1] which, among other things, criticized the health system for impersonal, fragmented, and confusing care. In one

chapter the authors drew a rather gruesome picture of the "medical experience." Many of their complaints are also heard from students, and I would like to mention a few of them:

(1) "Figuring Out What They Are Doing to You"

How often have patients wanted to know about the various costs and risks of illnesses and procedures only to be abrubtly told, "I'm the doctor!"?

(2) "Getting a Hearing If Things Don't Go Right"

How often is the patient allowed even a glimpse at an evaluation or an assurance of the quality of his medical care? How often is the patient treated with childlike deference and dependence if he begins to question what is being done to him?

(3) "Overcoming...Racism and Male Chauvinism of Doctors and Hospitals"

Do patients actually avoid using health services because they are afraid their dignity will be affronted by remarks about their sex, their morality, or their race?

Unfortunately, many consumers would have answered all those questions in the affirmative because there is little opportunity for recourse, "no Better Business Bureau for Health."(1)

At last year's conference banquet Dr. John Knowles very forcefully noted that health care in this country is very much like a monopoly, medically, socially and economically; and that the consumer has little opportunity to affect the product as in other consumer markets.(12) Another author even went so far as to indict health care financing as a subsidy for providers.(22)

Nevertheless, there is something very wrong if consumers feel powerless to affect this very important social contract. So, what's bugging consumers everywhere is also bugging students, one of whom told the conference last year, "most important I want the health service to lead the way in relating to young people as people, not as 'students' but as human beings."(20)

Again we are faced with the question whether the student is to be given equal status with other adult consumers, and I would dare say that the "student" label creeps in too often when most college health services look at their patients; it is this kind of dependent role definition which the colleges are equally guilty of perpetrating, and which actually inhibits students from acting as responsible consumers. In his presentation at Boston last year, Dr. Henrik Blum put it very accurately when he said, "I think it is more relevant to assume that good health for the student may be his ability to progressively more effectively cope with or enter into the process of achieving alterations of his environments. Such a role is often kept away from the student who is increasingly asked to postpone his entry into the real world long after he has felt the biological and social urges compelling him into tasks which he is somehow prevented from facing, defining, or challenging."(5)

The Role of the College in the College Health Service

An effective participatory role for the college student may partially be inhibited by the role society establishes in general; but another likely inhibitory factor may be the role of the college itself in running the health service. As Dr. Blum also pointed out, the goals of the institution may often be at variance with the goals of good health.(5)

As you well know there has been considerable discussion generated lately whether colleges should provide health services at all. The salient issue, however, is not that college students should be deprived of accessible and comprehensive health care, but rather that formal and legal control rest in the hands of the providers and the consumers. Why can't there be a college health service on campus that is, nonetheless, independent of the college administration? It appears, however, that the prevailing opinion of the A.C.H.A. and its members is that final authority should rest with the President or the College's Board of Trustees, which is in total variance with the fundamental principles of consumer participation. What can non-resident trustees know about the students' health needs? How is the college president to be held accountable for the quality of the health service? Does a private practitioner report to the Governor? Of course not. "It appears that the health service on many campuses has come under the aegis of the administration by two routes: by accident and by design. In the first case, the responsibility for staffing and maintaining the health service usually fell upon the educational institution because there was simply no one else who would assume the important responsibility for providing health care to a relatively captive, yet transient population group.

"In the latter case, either the health service was a natural application of the principal "in loco parentis," or it was a logical extension of a medical school. Regardless, the need exists to reexamine the basic assumptions concerning the university's relation to the health service."(20)

It is quite possible that present A.C.H.A. policy may be just a rationalization of habit, because it certainly is inconsistent with the concepts of accountability, and the student's right to conduct his life as an adult. In fact, it may very well be possible that college administrators would prefer not to have this heavy responsibility if they knew adequate care could be provided by an independent, self-supporting health service that used or leased campus facilities.

Finally, as long as the college has direct and final responsibility for health care there will always exist a rather unhealthy shrowd of suspicion over the integrity of the health service in areas of confidentiality, conflict of interest, and morality.

As you can probably tell, I am making the case that the college health service drastically modify its relations with the parent educational institution. I posit this not with any malice toward A.C.H.A., but rather so that the health service can become stronger unto itself and so that consumer participation will be meaningful and not just manipulative.

There is yet another reason why the health service should loosen its ties with the college and that is to allow for greater flexibility and a broadened base of operations. I was pleased to hear, for example, that A.C.H.A. is exploring the possibilities of utilizing college health services as Health Maintenance Organizations. This would indeed be possible, for as you know, there already exist college health services which could logically be suited as comprehensive community health centers. The benefits would be many: greater opportunities to ensure consumer participation and to provide comprehensive health care;

an improved medical environment for the professionals; a broadened financial base; and, yes, maybe even improved town-gown relationships.

Who Is Representative and How Shall They Participate?

Although I feel that effective participation and planning will require college health services to broaden their base and reduce their legal ties to the college, those possibilities are long-range, so perhaps I will conclude this section of the presentation by discussing some questions which are probably of more immediate concern to you.

The first question is how to select your consumer participants. One preliminary suggestion is that regardless of the particular procedure, "each program (should) have its own selection criteria based on functions as defined legally by charter or bylaws."[9a] Lack of clear cut procedures for selecting consumer representatives will only undermine confidence in the process. Secondly, the procedures ought not be arbitrary or based on the preferences of the providers. Third, the selection of consumer representatives should be periodically subject to challenge by other consumers. This would help assure some accountability to the representatives' constituents and would promote interest in the process; and finally, avoid if you can that arch-nemesis of consumer participation, the "informed" student. Too often has that catchword been used to mean agreeable, or polite, or premed but never representative. Interest alone ought to be sufficient criteria to get someone involved. More than one author has commented that provider's desires for "informed" consumers is really self-serving, because any consumer is already well informed about his own perceived needs.[9a,18,22] Neither is there any

guarantee that providers always know what is best for consumers. The history of professional self-regulation and the present health crisis are evidence that providers alone cannot provide all the answers.

The second question, then, assuming we are in agreement that participation is a worthwhile goal, is to what extent should consumers participate in planning and evaluation. The Notkins reported that "despite...signs of progress, actual consumer participation and/or control has been basically limited to certain program areas...The mainstream of medical care as represented by hospitals and professional associations has not been seriously affected."(15) Regardless of specific progress to date in college health programs or elsewhere, any future plans will require a rational typology of participation that will be both applicable and feasible depending on local circumstances. One planner has already developed one such typology called the "ladder of participation" that may be worth discussing here. It is basically eight progressive degrees of involvement that fall in the three categories of non-participation, tokenism, and citizen power and control. To date it appears that even the most progressive of the college health services are still operating in the category of tokenism which involves dissemination of information, consultation, placation and reaction. More meaningful sharing of actual decision making and delegation of powers is a topic of the future and will require critical reexamination and changes at most college health services.

In the meantime, however, the advice of student consumers has no formal sanction. As another planner noted, "If consumers are confined to advisory roles, their inputs are completely dependent upon the disposition

of the providers to accept them."(2) Some students, however, may be content with that capacity as was reported in one instance at last year's conference, but even that successful arrangement was admittedly dependent on a good rapport with the health service's director.(16)

Up until now, I have been largely concentrating on the more static aspects of consumer participation, which is really not sufficient to do justice to what is a dynamic process; so I would like to move on to the next section dealing with the role of the consumer-negotiator in actual planning and evaluation.

3.0 HEALTH PLANNING AND THE CONSUMER

"No Plan is Ideal, Only Agreeable"

The rise in status of the concept of health planning as a means to allocate resources is due in large part to the failure of the free market ideal which assumed that competition among providers and free choice of the consumer would mitigate the need for regulation of the health care system because all future outcomes would be satisfactorily accommodated by freely operating supply and demand factors. The desire for planning, then, is really an *a priori* assumption on society's part that future outcomes would be undesirable without planning; in this regard planning is really a form of insurance and a means to institute new criteria for accommodating supply, demand, *and* need. I have added need, here, because the gap between consumers' needs and their demands is a major or causative factor in the demise of laissez faire health care. The market analysis is a fascinating topic but there isn't enough time to deal with it completely here. I would like to come back to the subject in the last section of this paper however, in discussing the social contract aspects of health care.

In the meantime, I would like to review some definitions of planning to reveal that community health planning is not only a technical process, but it is also a political one.

In a report from the National Commission on Community Health Services, Dr. Ralph Conant wrote, "Community health planning in the broadest sense is the effort to bring together and make rational use of private and public resources...in such a way as to meet all important health problems in the community including the health problems of...

disadvantaged segments of the population...Community health planning must periodically reevaluate goals and standards in the light of new or refined technical knowledge and changing values."(8)

Robert Binstock defined effective planning as the "achievement of public health planning goals: that is, the realization of efforts to modify the amount, the quality, the accessibility, the range and the configuration of health services, goods, and facilities provided for people."(4) He also went on to point out that health planning is political regardless of who does the planning. Dr. Henrik Blum also strongly emphasized the point that values affect planning criteria;(5) and a number of other authors have stressed that power is a fundamental issue in the determination of programs and pllicies.(1,2,4,7,9a,14,15,18,22)

Basil Mott has pointed out that as long as people have differing views then political influence becomes the means of achieving goals and objectives, and that the strictly technical or rational dicision model ignores social realities and is politically naive.(14) Mary Arnold has described health planning as "the political process of obtaining consensus and resolving conflict."(2) Planning however, need not be composed entirely of technical nor political considerations, so I would like to outline what are some essential steps in health planning where these considerations impact, regardless of who is doing the planning:

(1) Measurement of health care in terms of limited and imperfect information.

(2) Formulation of preferences and values for health care programs and policies.

(3) Evaluation of health care in terms of those measurements and preferences.

(4) Establishing criteria and alternative plans for achieving the goals.

(5) Implementation of various plans.

(6) Measurement of outcomes and subsequent reevaluation, and the process begins all over again.

In a sense, then, planning is an iterative loop that has no limit; it could be days or it could be years, because it is a continuous and dynamic activity.

In all these various steps, however, the consumer has had very little impact and the providers dominate. Measures of effectiveness are often designed according to the providers' orientation whether it is numbers of hospital beds, or physician visits, instead of consumer satisfaction or improved health status.(2) Formulation of program and policy goals is again the domain of providers who often believe that they alone know what is best and who can successfully manipulate consumers by pulling professional rank. Evaluation is one area where the consumer has been totally excluded; medical audit, utilization review, and personnel evaluations are considered none of the consumer's business; as a result the public has been forced to go on blind faith that professional self-regulation is adequate. Implementation of programs and policies is still another area where the consumer has been left in the dark; while this is the provider's direct responsibility there are very few means by which the consumer can be assured that implementation proceeds effectively.

So while on one level setting program goals is a technical matter, when there are conflicting goals it becomes a political matter; and there are no hard and fast rules or measures by which to ultimately judge the outcomes of medical care.

In the broadest sense health care is a political goal when one considers that health must compete with defense, education, transportation, etc. At a more specific level, for example, lowering the infant mortality rate is a political goal, in part, simply because it is a major concern to many people, and in part because trade-offs have to be made with other programs. And on the college campus these same value delimmas are present: are there any clear cut medical measures why athletic medicine would be more important than a birth control clinic, or a dental clinic? There are always reasons pro and con, but ultimately it is a question of preferences which should decide.

But suppose, for example, that the systems analysts and medical researchers could give us some concrete numbers representing the effectiveness of health care programs (and, indeed, some very interesting work is being conducted) in terms of cost-benefit and cost effectiveness, etc; those measures will be in terms of things like added years of economically productive life, degrees of reduced disability, discomfort, etc. But who has the right to determine whether productive man years is more important than, say, reducing discomfort for the aged? Even while systems analysts and the medical professionals could calculate things like cost-benefit ratios, what is to be measured is an inherent right of society's

Thus, planning ought to ideally combine the technical expertise of the providers with the desires and felt needs of the consumers. As Dr. Blum said last year, "no plan is ideal, only agreeable."(5)

Planning Is a Process of Negotiation and Compromise

When Dr. Blum spoke of a plan being "agreeable" he was assuming that the process involved negotiation and compromise among the participants. Most of health planning to date has probably been agreeable because those doing the planning have been the providers who tend to be a relatively homogeneous group, and compromises are made on the professional's terms. If consumers are to be included in the process, however, providers will be faced with a completely different milieu in which conflict is to be resolved. This is a matter which ought to be of prime concern to college health services which may be considering consumer participation. Consumers who demonstrate for a birth control clinic are already part of the health planning process because they are trying to force the issue of negotiation which they may feel has been denied. A formal planning mechanism is far more likely to respond to changing needs and demands and would mitigate the need for confrontation.

Before going into the various strategies and incentives that operate in planning I would like to list some important principles and prerequisites that two authors have presented for community health planning.

Dr. Ralph Conant listed five essential ingredients, all of which could be operative on college campuses if the institutions are willing to make changes.

(1) "Knowledgeable, determined leadership especially skilled in identifying and resolving conflicts among a wide variety of contending interests"

(2) "A source of legal authority and enforceable sanction"

(3) "A reliable source of money in proportion to established goals"

(4) "Capacity to combine the public and private resources of the community"

(5) "A capacity for skilled analysis of community health problems."(8)

Mrs. Anne Somers of Princeton University has written that effective planning is not really in existence, and she suggested several principles, a few of which are especially applicable to college health services:

(1) "To be fully effective health care must be provided in a coordinated, comprehensive fashion," that maintains the doctor-patient relationship and accountability for professionals.

(2) "The American people are committed to a policy of one class, one door high quality medical care available to all" that does not perpetrate the "separate but equal" practice.

(3) "Health institutions and services must be community controlled. The welfare of the community is not best served when either providers or consumers exercise exclusive control."

(4) "Hospitals and other large health care institutions can usually strengthen their community roles as well as their finances by diversifying their sources of income."

(5) "The most important single guarantee of good health services for the future is the existence of a strong community-wide planning mechanism which is responsive to the changing needs of both providers and consumers of care which will permit continuing adjustment in services and facilities in keeping with these changing needs."(19)

But if you are to go ahead with a partnership with your consumers then the various strategies and incentives have to be understood and accounted for before planning participants can successfully operate and negotiate.

The first thing to be considered is that individuals and institutions instinctively resist change. Robert Binstock wrote, "Organizations do not tend to resist innovation because they are ignorant of facts, or because they are illogical. Rather they are predisposed to resist changes embodied in health planning goals regardless of the facts."(4) The literature on organizational behavior is replete with convincing arguments to this effect.

The second phenomenon to be considered is that individuals and organizations act according to their own perceived self interests.

A third phenomenon is that individuals and institutions vigorously defend their perceptions of the world. In a planning context this means that people will take actions that will justify perceptions that may in fact be faulty. This is the idea of the self-fulfilling prophesy.

Given these preconditions, any health planning participants will be operating under various constraints and incentives. In practice, it is the professionals who have dominated because they have tended to hold unfair advantage over the consumers. Dr. Peter Rogatz presents three overriding factors for this dominance in health planning activities:

(1) "Professional stigma" and mystique.

(2) "Professionals have emotional and economic stakes," far stronger than for consumer representatives.

(3) Health planning is "professional turf" in that consumers can very easily be outmaneuvered at meetings, etc.(18)

A number of authors have also pointed out that plans "end up reflecting the provider's (perceived) needs,"(22) and that institutions "act according to what they can get, not according to what is actually needed."(6)

Dr. Rogatz concluded his analysis with the suggestion that "these new values (regarding consumer participation) need to be incorporated into an incentive system" so that consumers can be afforded "points of leverage" without resorting to the media, third party payers, and accrediting bodies.(18)

In speaking about incentives and self-interest, I hope you don't get the impression that I'm accusing college health services of

being a bunch of self-seeking ogres. Rather I want to make the point that institutional constraints have a great deal to do with what kind of planning you have and how people are treated. Take for example excuses for gym or examinations. If the student knows that the health service will give him an excuse he may take advantage of it, and the professionals will, in turn, tend to think that's all many students want. It's really very condescending for a physician to instinctively ask a 23 year old graduate student if he wants a gym excuse. But that sort of thing goes on all the time.

In terms of planning programs and policies there are a number of means by which consumers are "put off" by the health service.

One common strategy is to ask the student consumers to report on the needs of the "average student." First, that is a poor planning practice and second the tactic begs the question. As John Gardner, former Secretary of HEW, wrote, "If we waited for the middle to move itself we would all still be in caves."

Another common method of student involvement is the "suggestion box,"[16] which may be useful for some small matters, but it is totally dependent on the professionals for disposition.

Another ad-hoc strategy is to respond to consumer demands with, "give us a constructive alternative." What this sounds like is that only a 50 page report with glossy cover, charts, tables and appropriate recommendations will ever get a hearing from the providers. But the consumer is in no way obligated to do the professional's job. Nor can the consumer begin to help generate alternatives until he is let in the door to decision making which will be a major change indeed for most college health services.

Any specific role that allows for your student consumers will, of course, depend in large measure, to what extent you agree with some of the fundamental concepts that have been presented. In terms of program areas let's refer back to the 1954 A.C.H.A. committee which encouraged student participation in "(1) range and type of services to be provided, (2) operational convenience and effectiveness, and (3) general and financial policies..."(20)

At last year's conference the student task force made a number of recommendations to the effect that consumers be given proportional representation in decision making, and college credit or some reimbursement be afforded so that incentives for consumer representatives would be on a parity with that for the providers.

Finally, I would like to suggest that consumers be involved in such activities as utilization review to guarantee what one author called the consumer's "need to know...and be assured of quality."(18)

4.0 THE HEALTH CARE SOCIAL CONTRACT

In conclusion, I would like to reiterate some of the main points of the paper and to suggest a context for the role of consumers in planning and evaluation, whereby health care is part of a social contract between providers and consumers.

The first point that is fundamental to this paper is that the consumer (students included) has a right to act as a free agent in seeking health care. Concomitantly the consumer has the right to representation when it comes time to negotiate for his care. Second, the providers have a right to negotiate for what they feel are adequate reimbursement, appropriate professional settings, etc. Third, ultimate control and responsibility for health care should belong to the community. Fourth, the integrity of the doctor-patient relationship should be maintained; and fifth, administrative responsibility for the college health service should be critically reexamined for the impact on comprehensiveness and continuity.

I feel that all these principles can be implemented if consumers and providers would be willing to plan together in the context of a social contract.

One of the assumptions here is that a responsive and effective health care system requires understandable and accountable contracts. It is possible to describe any "system" as the function of a set of contractual arrangements, in order to better evaluate the "products" of the system and to revise the criteria and the goals as deemed necessary.

In economics, one conceives of "elasticity" as a measure of the response of the suppliers to the changing (or potential change)

consumer demands. In political terms, this is accountability, and it is clear that health care consumers are becoming increasingly dissatisfied with the responsiveness and the "products" of the delivery system: Morbidity and mortality statistics are less than impressive; the average consumer does not perceive that his "felt needs" are being met; the costs of medical care are rising out of the reach of the average consumer; and, finally, the health industry has been relatively lax in assuming leadership in the solution of these problems.

Part of the problem can be ascribed to the dysfunction of the "non-system"; but another major fault lies in the fact that consumers and providers have not yet agreed to just what the health care "contract" means to everyone in terms of benefits and responsibilities that are supposed to characterize the relationship.

Any health care system is subject to many of the same pressures that characterize an economic market, although the "products" of health care are often intangible and not easily measured in dollars and cents. Nevertheless a non-monetary analogy is plausible. College health services, in particular are a good example where there is little opportunity for the consumer to affect the supply function by his demand because the supplier is likely to get paid and supported regardless of satisfaction and regardless of the fact that students may go "down town" to get their health care (especially in cases of the mandatory health fee, where the only choice open to the consumer is to leave school, if he does not wish to pay the fee).

In conversations prior to and during the Fifth National Conference, it became clear that a large number of students and providers

are not aware of just what their responsibilities and benefits were supposed to be, and that there were few colleges where there are mechanisms to define the "contract."

Contracts are essentially a means by which consumers and providers can protect themselves and establish rules for reaching some kind of supply and demand equilibrium. Two basic rules must apply: (1) resources or services that are exchanged according to contract provisions can be withheld upon reasonable non-compliance by the other parties, according to some preestablished procedure; and (2) the contract should be renewed at reasonable intervals to insure surveillance of the parties' compliance.

The contracting process parallels the market process in the following ways: (1) negotiation, compromise, and establishment of contract provisions; (2) some degree of compliance with the provisions by the parties involved; and (3) some degree of acceptance or satisfaction with the other parties' compliance, which in turn will affect (1). This is similar to the market process, except that it is not subject to day-to-day fluctuations, and herein lies the protection that contracts afford.

A health care system or model, then, can at any time be described by a set of contracts between and among any number of contracting parties; each of the provisions can, in turn, be described by degrees of compliance and understanding by the parties. It should be noted, however, that many of the provisions may be implicit; for example, the fact that a neighborhood health center provides employment for the indigenous population is a major provision of the "contract" although it may not be explicit.

It is the major contention of this memorandum that a more clearly defined relationship between the consumers and the providers is needed in order to improve the health care delivery system and that such relationships should be subject to reasonable revision.

REFERENCES

1. The American Health Empire: Power, Profits, and Politics, A Report from the Health Policy Advisory Center. Prepared by Barbara and John Ehrenreich, Vintage Books, New York, 1971.

2. Arnold, Mary F., "Basic Concepts and Crucial Issues in Health Planning," American Journal of Public Health, Vol. 59, No. 9., September 1969, pp. 1680-1697.

2a. Arnstein, S.R., "A Ladder of Consumer Participation," Journal of the American Institute of Planners, Vol. 35, July 1969, pp. 216-224.

3. Battistella, Roger M, "National Health Insurance and the Future of Public Health," Address before American Public Health Association, Houston, October 25, 1970.

4. Binstock, Robert H., "Effective Planning through Political Influence," American Journal of Public Health, Vol. 59, No. 5, May 1969, pp. 808-813.

5. Blum, Henrik L., "Comprehensive Health Program Planning and Development in the 70's," General Session Address, Fifth National Conference on Health in College Communities, Boston, April 15, 1970.

6. Brown, Douglas R., The Health Planning Process: A Study of Area-wide Hospital and Health Facility Planning Agencies in the United States, Doctoral Dissertation, Syracuse University, 1969.

7. Campbell, John, "Working Relationships between Providers and Consumers in a Neighborhood Health Center," American Journal of Public Health, Vol. 61, No. 1, January 1971, pp. 97-103.

8. Conant, Ralph W., The Politics of Community Health, Report of the Community Action Studies Project, National Commission on Community Health Services, Public Affairs Press, Washington, D.C. 1968.

9. Feingold, Eugene, "The Changing Political Character of Health Planning," American Journal of Public Health, Vol. 59, No. 5, May 1969, pp. 803-808.

9a. Galiher Claudia B., Needleman, Jack, and Rolfe, Anne J., "Consumer Participation," HSMHA Health Reports, Vol. 86, No. 2, February 1971, pp. 99-101

10. Hochbaum, G.M., "Consumer Participation in Health Planning: Toward Conceptual Clarification," American Journal of Public Health, Vol. 59, No. 9, September 1969, pp. 1698-1705.

11. Kane, Daniel, "Community Participation in the Health Services System," Hospital Administration, Vol. 16, Winter 1971, pp. 36-43.

12. Knowles, John H., Banquet Address, Fifth National Conference on Health in College Communities, Boston, April 15, 1970.

13. Memorandum of the Meeting of the Executive Planning Committee, Fifth National Conference on Health in College Communities, Evanston, Ill., June 22-23, 1970.

14. Mott, Basil J., "The Myth of Planning Without Politics," American Journal of Public Health, Vol. 59, No. 5, May 1969, pp. 797-803.

15. Notkin, Herbert, and Notkin, Marylyn S., "Community Participation in Health Services: A Review Article," Medical Care Review, Vol. 27, No. 11, December 1970, pp. 1178-1201.

16. Plumb, William and van Loewenfeldt, Paula M., "Student Participation in Student Health Programs," The Journal of American College Health Association, Vol. 19, No. 3, February 1971, pp. 174-176.

17. Remer, Robert, "A Contract Model for Analysis of Delivery Systems," Memorandum to Members of the Executive Planning Committee, Fifth National Conference on Health in College Communities, August 11, 1970.

18. Rogatz, Peter, and Rogatz, Marge, "Role for the Consumer," Social Policy, Vol. 1, No. 5, January/February 1971, pp. 52-56.

19. Somers, Anne R., "Some Suggested Principles for Community Health Planning and for the Role of the Teaching Hospital," The Journal of Medical Education, Vol. 43, No. 4, April 1968, pp. 479-494.

20. "Students and College Health," Position Paper, Task Force IX, Fifth National Conference on Health in College Communities.

21. Summary of Recommendations from Task Force Discussion Groups, Fifth National Conference on Health in College Communities.

22. de Vise, Pierre, "The Social Pressures: Consumers Revolt Against Medical Dictatorship," Hospitals, Vol. 45, February 1, 1971, pp. 51-58.